MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07916

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Cecil
City or town: Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State: Maryland County: Cecil
City or town: Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Port Deposit, Rising Sun Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Romeo Abrahams.

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Caroline
6.(c) If alive, give age: 77. years
7. Birth date of deceased (mo., day, yr.): Jan. 23, 1863
8. AGE: Years: 84 Months: 7 Days: 19 If less than one day: hrs. min.
9. Birthplace: Buckingham Va.
(Town, county, and state)
10. Usual occupation: machinist
11. Industry or business: auto.
12. FATHER Name: John W.
13. Birthplace: Baltimore, Md.
14. MOTHER Maiden name: Mattie A. Price
15. Birthplace: Va
16. Informant: Caroline Abrahams
Address: Port Deposit Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 14, 1947 (month) (day) (year)
Cemetery or crematory: Odd Fellows
Location: Port Deposit Md. Rural
18. Funeral director: Lee Patterson & Son
Address: Perryville, Md.
19. Sept 13 1947 (Date rec'd by registrar) Irene E. Douglass (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 11 1947 at 3P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1947 to Sept 11 1947 and that I last saw him alive on Sept 11 1947

	DURATION
Immediate cause of death: Uraemia	
Due to: myocarditis	3yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. F. Benson M.D.
M. D. or Coroner
Address: Port Deposit Md. Date signed: 9/13/47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18b

CERTIFICATE OF DEATH

07917 9C

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Perryville, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Perryville, Md., Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Frenchtown Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sarah Ann Bines

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William E. Bines

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 2, 1880

8. AGE:

Years	Months	Days	If less than one day
67	7	19	..... hrs. ..... min.

9. Birthplace: Perryville, Cecil Co., Md.

(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER

12. Name: Thomas Boyd

13. Birthplace: Cecil Co., Md.

MOTHER

14. Maiden name: Nettie Poplar

15. Birthplace: Harford Co., Md.

16. Informant: William E. Bines

Address: Perryville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 23, 1947 (month) (day) (year)

Cemetery or crematory: Asbury

Location: Port Deposit, Md., Rural

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Sept 23 19 47 (Date rec'd by registrar) Irene E. Douglass Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 22 19 47 at 12:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 19 47 to Sept 20 19 47 and that I last saw h... alive on Sept 20 19 47.

	DURATION
Immediate cause of death: Carcinoma of Uterus	4 yrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. W. Benson M. D.

M. D. or other

Address: Port Deposit, Md. Date signed: 9/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 1a

07918

CERTIFICATE OF DEATH

Reg. Dist. No. 75 Myer

1. PLACE OF DEATH:
County Cecilton md.
City or town
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 56 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Cecilton md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Finley Boyer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife Emma Boyer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 17, 1866

8. AGE:

Years	Months	Days	If less than one day
81	6		..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Housework

FATHER
12. Name John Boyer
13. Birthplace Maryland

MOTHER
14. Maiden name Jane —
15. Birthplace Maryland

16. Informant Mrs Emma Boyer
Address Cecilton, md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 15 (month) (day) (year)
Cemetery or crematory Cecilton
Location md.
18. Funeral director Austin O Caulk
Address 227 price St, Wilmington Del

19. Sept 16 1947 (Date rec'd by registrar) Mrs Thomas W. Clemens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1947 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2 1947, to Sept 11, 1947 and that I last saw h.. alive on Sept 9 1947

Immediate cause of death	DURATION
Chr. Interstitial nephritis	10 years
Chr. Myocarditis	12 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE James L. Johnson MD
M. D. or other
Address Elkton, Md. Date signed 9/22/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore.

CERTIFICATE OF DEATH

13 b

07919

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years and 2 months

Hospital, Institution, or street address where death occurred:

VAH, Perry Point, Maryland

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pennsylvania County:

City or town: R.D. 2, Darlington, Pennsylvania

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3. (a) FULL NAME: EDWARD J. BROWN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): November 9, 1892

8. AGE: Years	Months	Days	If less than one day
54	9	23	..... hrs. ..... min.

9. Birthplace: Cannelton, Pennsylvania (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business:

FATHER — 12. Name: John Brown - Deceased

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Anna Kennedy - Deceased

15. Birthplace: Ireland

16. Informant: Hospital Records

Address: Perry Point, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 3, 1947 (month) (day) (year)

Cemetery or crematory:

Location: Beaver Falls, Penn.

18. Funeral director: Pennington & Son

Address: Havre de Grace, Maryland

19. Sept. 3 1947 (Date rec'd by registrar) Irene E. Dunlock Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 2, 1947, at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1931, to Sept. 2 1947 and that I last saw him alive on September 2 1947

Immediate cause of death	DURATION
Tuberculosis Pulmonary, Chronic, Far Advanced, Active `3'	1 year
Due to:	
Due to:	
Other conditions: Psychosis, Residuals of Encephalitis, chr., Parkinsonian Synd.	15 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: No Autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury: Injured at work?

23. SIGNATURE: A.E. Trollinger

A.E. TROLLINGER, M.D., Clin. Director

Address: VAH, Perry Point, Md. Date signed: 9-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

157e 07929

Reg. Dist. No. 95

1. PLACE OF DEATH:
County Cecil
City or town Rising Sun
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Cecil
City or town Rising Sun
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Harry Osborne Burkins

3.(b) Social Security Number: 217-16-3633

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Elizabeth Burkins
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Aug. 16 1889

8. AGE: Years	Months	Days	If less than one day
58		26	hrs. min.

9. Birthplace: Rising Sun, Md.
(Town, county, and state)

10. Usual occupation: Lab.

11. Industry or business

FATHER
12. Name: Alfred Burkins
13. Birthplace: Harford County, Md.

MOTHER
14. Maiden name: Laura S[illegible]Shade
15. Birthplace: Maryland

16. Informant: Elizabeth Burkins
Address: Rising Sun, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 15 1947 (month) (day) (year)
Cemetery or crematory Brookview
Location Rising Sun Md.

18. Funeral director J. E. Tyson
Address Rising Sun Md.

19. Sept 13 1947 (Date rec'd by registrar) E. M. Worthington Registrar

Permit issued Sept 13-47

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 11 19 47 at 10.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 19 46 to 9-11 19 47 and that I last saw h[illegible]im alive on 9-11-47 19

Immediate cause of death	DURATION
Chronic Valulitis with Cardiac Decompensation	3wks
Due to Congenital Heart Disease	lifetim
Due to Chronic Nephritis	2years
Other conditions Coronary Sclerosis	2years

(Include pregnancy within 3 months of death)

Major findings of operation None
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R.C.Dodson, M.D. Medical Examiner for Cecil County
Address RISING SUN, MD. M. D. or other
Date signed 9-12-47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

07921

Reg. Dist. No. 95

1. PLACE OF DEATH:

County Cecil

City or town Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil

City or town Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emma Scott Cameron

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Robert Cameron

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 29. 1856

8. AGE:

Years	Months	Days	If less than one day
91	0	13	..... hrs. ..... min.

9. Birthplace Lewisville Pa. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER

12. Name Thomas Scott

13. Birthplace Pa

MOTHER

14. Maiden name Mary Strickland

15. Birthplace Pa

16. Informant Walter Cameron

Address Rising Sun. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 15 1947 (month) (day) (year)

Cemetery or crematory West Nottingham

Location Near Colora. Md

18. Funeral director J. E. Tyson

Address Rising Sun. Md.

19. Sept. 13 1947 (Date rec'd by registrar) Registrar

Burial Permit Issued Sept. 13-47

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1947, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 15 1947, to 9-12 1947

and that I last saw her alive on 9-12 1947

Immediate cause of death	DURATION
Cardiac failure	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. E. Dodson M.D. M. D., or other

Address Rising Sun Md Date signed 9-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07922

932

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH

County: Cecil Co

City or town: Port Deposit md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Rowlandville md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Solomon Christie

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 11 - 1881

8. AGE:

Years	Months	Days	If less than one day
66	10	10	..... hrs. ..... min.

9. Birthplace: Rowlandville md.

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Thomas Christie

13. Birthplace: Perryville md.

MOTHER

14. Maiden name: Amanda Bayard

15. Birthplace: Rowlandville md.

16. Informant: Nellie Webster

Address: Port Deposit md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 23 1947 (month) (day) (year)

Cemetery or crematory: Lebanon, Pa.

Location: Yorks, Pa.

16. Funeral director: J. E. Tyson

Address: Rising Sun md.

19. Sept 22 1947 (Date rec'd by registrar) Lem Worthington (Registrar)

Permit issued Sept 23-47

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-20 19 47 at 10:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-1 19 47, to 9-20 19 47

and that I last saw h.. alive on 9-19 19 47

	DURATION
Immediate cause of death: Myocardial Insufficiency	Several years
Due to: Chronic	
Due to:	
Other conditions: Hypostatic Pneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Port Deposit md Date signed: 9-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The form is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93 e

07923

CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Cecil.
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs.
Hospital, institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil.
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: East Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Augusta Deacon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh.	Widowed

6.(b) Name of husband or wife: John H. Deacon
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1865

8. AGE: Years	Months	Days	If less than one day
82			hrs. min.

9. Birthplace: Frankford Germany
(Town, county, and state)
10. Usual occupation: at Home
11. Industry or business:

FATHER
12. Name: Fredrick Rukdeschel
13. Birthplace: Frankford, Germany

MOTHER
14. Maiden name: Margaret Becker
15. Birthplace: Germany

16. Informant: Mrs. Sidney Dixon
Address: Elkton, Md.

17. B. Interment + Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 27-/47 (month) (day) (year)
Cemetery or crematory: Old Lutheran
Location: Metropolitan Ave. New York City, N.Y.

18. Funeral director: H. W. Pippin
Address: Elkton, Md.

19. Sept 26 1947 (Date rec'd by registrar) H. R. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25 1947, at 3 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 23 1947 to Sept 25 1947 and that I last saw h.. alive on Sept. 24 1947

Immediate cause of death	DURATION
Cerebral Accident	2 days
Due to	
Due to	
Other conditions: Bilateral Cataract. Myocarditis (Include pregnancy within 3 months of death)	

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Dr. Lloyd H. Sprecher, M.D. M. D. or other
Address: Elkton, Md. Date signed: Sept 26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47d 07924

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil County

City or town: Elkton - Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Union Hosp.

How long in hospital or institution? 38 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Charlestown - Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Dougherty

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 30-1876

8. AGE: Years: 70 Months: 10 Days: 5 If less than one day: ..... hrs. ..... min.

9. Birthplace: Philadelphia Pa (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: about Elkton

MOTHER FATHER

12. Name: John J. Dougherty

13. Birthplace: Unknown

14. Maiden name: Ella Potts - Unknown

15. Birthplace: Unknown

16. Informant: The deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-7-47 (month) (day) (year)

Cemetery or crematory: Charles Town

Location: Charlestown Maryland

18. Funeral director: H. W Pippin & Son

Address: ELKTON Md.

19. Sept 7 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 4th 1947, at 8.20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 19 1947, to Sept 4 1947 and that I last saw him alive on Sept 4 1947

Immediate cause of death	DURATION
Carcinomatosis	
upper lobe of lung	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. H. McKnight M.D. M. D. or other

Address: Elkton Md Date signed: 9-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07925

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs. 9 mos. 9 das.

Hospital, Institution, or street address where death occurred:

VAH, Perry Point, Md.

How long in hospital or institution? 7rs. 9 mos. 11 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 638 W. Franklin Street

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: CHARLES R. EBBERTS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): August 29, 1888

8. AGE:

Years	Months	Days	If less than one day
59	0	19	____ hrs. ____ min.

9. Birthplace: Great Falls, Mont. (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER

12. Name: Charles Ebberts - Deceased

13. Birthplace: Unknown

MOTHER

14. Maiden name: Mary Allen - deceased

15. Birthplace: Unknown

18. Informant: Hospital Records

Address: VAH, Perry Point, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9-19-47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Pennington & Son

Address: Havre de Grace, Maryland

19. Sept. 19 1947 (Date rec'd by registrar) Irma E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18th 1947 at 3 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9 1939 to Sept. 18th 1947 and that I last saw him alive on September 18th 1947

Immediate cause of death	DURATION
Pneumonia, bronchial, bilateral	4 days
Due to Carcinoma, bronchogenic, left with metastasis to the mediastinal lymph nodes and to the left pleura and liver	2 yrs.
Due to	
Other conditions: Arteriosclerosis, generalized	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: —— Date of ——

Where did injury occur? —— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ——

Means of injury: Injured at work?

23. SIGNATURE: A. E. Trollinger A. E. TROLLINGER, M.D., Clin. Director

Address: VAH, Perry Point, Md. Date signed: 9-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1646 CB 07926

CERTIFICATE OF DEATH

Reg. Diat. No. 9791

1. PLACE OF DEATH:

County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? En Trip

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pa. County: Philadelphia

City or town: Philadelphia

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1607 N. 52 Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Raymond G Hagee.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Helen Hagee

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): March 31, 1907

8. AGE: Years	Months	Days	If less than one day
40	5	3	...hrs. ...min.

9. Birthplace: Phila Pa (Town, county, and state)

10. Usual occupation: Maintenance Employee

11. Industry or business: P.R.R.

MOTHER FATHER

12. Name: George Hagee

13. Birthplace: Phila Pa

MOTHER

14. Maiden name: Blanch Robert

15. Birthplace: Pa

16. Informant: Mrs Helen Hagee

Address: 1607 N 52nd St Phila Pa

17. Burial & Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 10/47 (month) (day) (year)

Cemetery or crematory:

Location: Philadelphia Pa

18. Funeral director: H W Tippin

Address: Elkton, Md.

19. Sept 6 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3 1947 at 2360 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death: Drowned.

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: 9-3-47

Where did injury occur: Chesapeake City Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Chesapeake & Del. Canal

Means of injury: Jumped from steamer

23. SIGNATURE: R L Dodson M.D. Medical Examiner Cecil County

M. D. or other

Address: Elkton Md Date signed: 9-6-47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07927

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 90

NV

1. PLACE OF DEATH:
County: Cecil
City or town: near Cecilton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County:
City or town: Boothwyn - R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Patrick Hicks.

3. (b) Social Security Number: 179-22-0092

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 31 1929

8. AGE: Years	Months	Days	If less than one day
18			hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Clyde D. Hicks
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Lillian Goodbar
15. Birthplace: Virginia

16. Informant: Clyde D. Hicks
Address: Boothwyn. Pa. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 19 1947 (month) (day) (year)
Cemetery or crematory: Sloan Cemetery
Location: Boothwyn, Pa.

18. Funeral director: Edward Fellows.
Address: Millington, Md.

19. Sept 17 1947 (Date rec'd by registrar) Mrs Hazel W. Chaney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16 1947, at 11:30 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw him alive on September 16 1947
Immediate cause of death: Compound fracture of skull — DURATION
Due to:
Due to:
Other conditions: Comp. fracture femur - left and abrasions of right side of chest & neck
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Sept. 16, 1947
Where did injury occur? near Cecilton Cecil (County) Maryland (State)
(City or town)
Injured at home, farm, industry, public place (where?) Highway - Rt. 213
Means of injury: Motor cycle — Injured at work?

23. SIGNATURE: Mc Lord H. Sprecher M.D.
Address: Elkton, Md. County Medical Exam. M. D. or other
Date signed: Sept 16, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 123

CERTIFICATE OF DEATH

07928

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months 11 days

Hospital, Institution, or street address where death occurred:
VAH, Perry Point, Md.

How long in hospital or institution? 9 months 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Ingleside Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: SAW

3.(a) FULL NAME: CHARLES F. JOYCE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Estelle Joyce

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Sept. 11, 1874

8. AGE: Years	Months	Days	If less than one day
73	0	17	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business:

FATHER — 12. Name: Thomas Joyce
13. Birthplace: Unknown

MOTHER — 14. Maiden name: Sophia Schwatka
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: VAH, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 10-1-47 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: Baltimore, Maryland

18. Funeral director: Pennington & Son

Address: Havre de Grace, Maryland

19. Sept 30 19 47 (Date rec'd by registrar) Irma E. Dornbrook (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28 19 47, at 8:50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-17 19 47 to 9-28 19 47 and that I last saw h... im ...alive on 9-28 19 47

Immediate cause of death	DURATION
Peritonitis, Acute	less than 1 week
Due to: Diverticulitis, descending colon	Unknown
Due to:	
Other conditions: Arteriosclerosis, generalized	Unknown

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: —— Date of ——

Where did injury occur? —— (City or town) —— (County) (State)

Injured at home, farm, industry, public place (where?) ——

Means of injury —— Injured at work? ——

23. SIGNATURE: A.E. Trollinger

A.E. TROLLINGER, M.D., Clin. Director

Address: VAH, Perry Point, Md. Date signed: 9-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

07929

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs.
Hospital, Institution, or street address where death occurred:
304 Elkton Blvd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 304 Elkton Blvd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elva Blackson McCloskey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Wh.	Married.

6.(b) Name of husband or wife: Herbert McCloskey
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): February 10, 1894

8. AGE: Years	Months	Days	If less than one day
53	6	24	...hrs. ...min.

9. Birthplace: Cecil Co Maryland
(Town, county, and state)
10. Usual occupation: at Home
11. Industry or business:

FATHER
12. Name: Charles Blackson
13. Birthplace: New Jersey

MOTHER
14. Maiden name: Clarissa M. Henderson
15. Birthplace: Delware

16. Informant: Herbert McCloskey
Address: Elkton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 7, 1947 (month) (day) (year)
Cemetery or crematory: Head of Christina
Location: New Newark Del
18. Funeral director: H.W. Pippin
Address: Elkton, Md

19. Sept 6 1947 (Date rec'd by registrar) F.R. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 3 1947 at 2:07 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 15 1947 to Sept. 3 1947
and that I last saw h.. alive on Sept. 3 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	3 wks.
Due to: Malignant hypertension	Appx. 2 yrs.
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: S. Ralph Andrews Jr. M.D.
M.D. or other
Address: 233 E. Main St. Elkton, Md. Date signed: 9/6/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9/a

07930

CERTIFICATE OF DEATH

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: CECIL

City or town: Perry Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14½ hours

Hospital, institution, or street address where death occurred:

Veterans Administration Hospital

How long in hospital or institution? 14½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 212 Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war: World War-I ✓

3.(a) FULL NAME: William James MCFADDEN

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife: Bertha Basquill

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 4, 1896

8. AGE:

Years	Months	Days	If less than one day
51	3	2	..... hrs. ..... min.

9. Birthplace: Berwyn, Chester Co., Penna.

(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business:

FATHER — 12. Name: Hugh McFadden - deceased

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Sarah Lynch - deceased

15. Birthplace: Unknown

16. Informant: Hospital records and wife

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 10, 1947 (month) (day) (year)

Cemetery or crematory: Beverly National Cemetery

Location: Beverly, New Jersey

18. Funeral director: Pennington & Son

PENNINGTON & SON

Address: Havre de Grace, Md.

19. Sept 8 1947 (Date rec'd by registrar) Irene E. Daughaday Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 September 1947 at 6:15 ▲ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h ..... alive on ..... 19.....

Immediate cause of death	DURATION
Endocarditis, acute, bacterial	Unknown
Due to	
Due to	
Other conditions	
Broncho-pneumonia, left	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ——

Date of op. .....

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: —— Date of .....

Where did injury occur? —— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ——

Means of injury —— Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner Cecil County

M. D. or other

Address: Perry Point Md. Date signed 9-6-47

07931

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: CECIL

City or town: Perry Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs. 8 mos. 22 days

Hospital, institution, or street address where death occurred:
Veterans Administration Hospital

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Cabell

City or town: Huntington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1810 Bungalow Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME

ALLEN WALKER PRINCE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mabel Carson

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): May 7, 1897

8. AGE:

Years	Months	Days	If less than one day
50	4	7	..... hrs. ..... min.

9. Birthplace: Huntington, Cabell Co., W. Va.
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business

FATHER
12. Name: James Gibbs Prince
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Nora Davis
15. Birthplace: Wayne Co., West Virginia

16. Informant: Mabel C. Prince, wife
Address: 159 Cedar St; Huntington, W.Va.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 15, 1947 (month) (day) (year)

Cemetery or crematory: Woodmere Cemetary,
Location: Huntington, West Virginia

18. Funeral director: PENNINGTON & SON
Address: Havre de Grace, Maryland,

19. Sept 15 1947 (Date rec'd by registrar) Irene E. Daugherty (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 September 1947 at 1:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 22 1930, to Sept. 14, 1947 and that I last saw him alive on September 14, 1947

Immediate cause of death	DURATION
General paralysis of the Insane	Unknown
Due to	
Due to	
Other conditions: Pneumonia, bronchial, left 3-4 days	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work?

23. SIGNATURE: A. E. Trollinger M.D.
A. E. TROLLINGER, M.D., M.D. or other
Address: Perry Point, Md. Date signed: 9-14-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 90

07932

MV

1. PLACE OF DEATH:

County: Cecil

City or town: New Cecilton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pa. County:

City or town: Boothwyn Pa. R.F.D

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: Yes. World War II.

3.(a) FULL NAME: Fred F. Smith

3.(b) Social Security Number: 176-20-6811

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 26, 1928

8. AGE:

Years	Months	Days	If less than one day
19			..... hrs. ..... min.

9. Birthplace: Penna.

(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business

FATHER

12. Name: Joseph Smith

13. Birthplace: Pa.

MOTHER

14. Maiden name: Mary Bunnell

15. Birthplace: Pa.

16. Informant: Joseph Smith

Address: Boothwyn, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 19, 1947 (month) (day) (year)

Cemetery or crematory: Calvary cemetery

Location: Rockdale, Pa.

18. Funeral director: Edward Fellows

Address: Millington, Md.

19. Sept 17 1947 (Date rec'd by registrar) Mrs. Howard W. Cheyney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16 1947, at 11 30 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19....

and that I last saw him alive dead on September 16 1947

Immediate cause of death	DURATION
Compound fracture of skull	
Due to	
Due to	
Other conditions: Compound fracture of femur, left and associated injury to chest and neck.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Sept 16, 1947

Accident, suicide, or homicide. Date of

Where did injury occur? Route 213 - near Cecil the (City or town) Cecil (County) Md. (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Motorcycle injury. Injured at work?

23. SIGNATURE: Dr. Lloyd H. Doweller, M.D. Deputy Coroner or other

Address: Elkton, Md. Date signed: Sept 16

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 54a

CERTIFICATE OF DEATH

07933

Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Cecil

City or town North East R D 1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Cecil

City or town North East Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war not a veteran

3.(a) FULL NAME John A Stoppel

3.(b) Social Security Number 217-24-6388

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11-3-1928

8. AGE:

Years	Months	Days	If less than one day
18	10	9	..... hrs. ..... min.

8. Birthplace North East R 1 Cecil Co Md
(Town, county, and state)

10. Usual occupation School Boy

11. Industry or business —

FATHER
12. Name William Stoppel
13. Birthplace Oxford Maryland

MOTHER
14. Maiden name Loretta Oldham
15. Birthplace North East Cecil Co Md

16. Informant Mrs William Stoppel

Address North East R D 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 16 47 (month) (day) (year)

Cemetery or crematory Methodist

Location Bay View Md

18. Funeral director Joseph R. Evans

Address North East Md

19. Sept 16 1947 (Date rec'd by registrar) Lida V. Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Sept 1947, at 6:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Feb '47 to 12 Sept 1947

and that I last saw h.[illegible] alive on 12 Sept 1947

Immediate cause of death Brain Tumor (Glioma) — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations R. hemisphere Glioma. Date of op. 10 Feb '47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Sadowsky MD M. D. or other

Address Perryville Md Date signed 12 Sept '47

Evidence for the clarrification of last name is shown on C 112 9/15/47

07934

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil

City or town Elk Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Elk Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME O Thomas Stump (Stumph)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	married

6.(b) Name of husband or wife Eloy Hall Stump

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19 1878

8. AGE: Years 69. Months Days 17. If less than one day hrs. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business

FATHER 12. Name Henry T Stump

13. Birthplace Va.

MOTHER 14. Maiden name Eliza Basham

15. Birthplace Va.

16. Informant Geo Eloy Stump

Address Elk Mills Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 9/47 (month) (day) (year)

Cemetery or crematory Elkton

Location Elkton, Md

18. Funeral director H W Pippin

Address Elkton, Md

19. Sept 6 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH. September 5 1947 at 9P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death Acute Coronary disease — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R L Dodson M.D. Medical Examiner for Cecil County

Address Rising Sun Md M. D. or other Date signed 9-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

07935

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OE DEATH:

County Cecil

City or town Port Deposit, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Seat Pleasant, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harry T. Taylor

3.(b) Social Security Number 716-03-1189

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife Viola B. Lockette 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1885

8. AGE: Years	Months	Days	If less than one day
61	11	24	hrs. min.

9. Birthplace Bowie Md.
(Town, county, and state)

10. Usual occupation Draw Tender

11. Industry or business Penna. Railroad

FATHER 12. Name John W. Taylor

13. Birthplace Maryland

MOTHER 14. Maiden name Annie E. Bunnell

15. Birthplace Maryland

16. Informant Mrs. Stanley Craig

Address Port Deposit, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-23-47 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Baltimore Blvd., U.S. Route 1, Md.

18. Funeral director Lewis Patterson & Son.

Address Perryville, Md.

19. Sept. 21, 1947 Irma E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1947 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 1947 to Sept. 21 1947 and that I last saw h. im alive on Sept. 14 1947

Immediate cause of death	DURATION
Coronary Thrombosis	Immediate
Due to Angina Pectoris	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. F. Magraw M. D. or other

Address Perryville, Md. Date signed 9/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07936

131a

CERTIFICATE OF DEATH

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months 8 days

Hospital, Institution, or street address where death occurred:
VAH, Perry Point, Md.

How long in hospital or institution? 1 year 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME: JOHN VITUCOVITCH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.): 1894

8. AGE: Years	Months	Days	If less than one day
53			....hrs. ....min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: Mess Attendant

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Hospital Records

Address: VAH, Perry Point, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 10-1-47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Runnette & Son

Address: Havre de Grace, Maryland

19. Sept 30 19 47 Irene E. Dougherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25 19 47 at 4:47 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17, 19 47 to Sept. 25 19 47 and that I last saw him alive on September 25 19 47

Immediate cause of death	DURATION
Uremia	4 days
Due to: Hypertensive cardiovascular renal disease	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: —— Date of ——

Where did injury occur? —— (City or town) —— (County) (State)

Injured at home, farm, industry, public place (where?) ——

Means of injury ——— Injured at work? ———

23. SIGNATURE: A. E. Trollinger

A.E. TROLLINGER, M.D., Clin. Director

Address: VAH, Perry Point, Md. Date signed: 9-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07937

472

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Union Hospital – Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place at death? 54 days.

Hospital, institution, or street address where death occurred: Union Hosp.

How long in hospital or institution? 54 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 110 Bethel Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Enoch Wilson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	Married

6.(b) Name of ~~husband or~~ wife: Alice Wilson

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 2 June 1887

8. AGE:

Years	Months	Days	If less than one day
60	7	21	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

MOTHER FATHER

12. Name: George Wilson

13. Birthplace: Maryland

MOTHER

14. Maiden name: Henrietta Cork

15. Birthplace: Maryland

16. Informant: Alice Wilson

Address: 110 Bethel St. Elkton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/2/47 (month) (day) (year)

Cemetery or crematory: Providence Cemetery

Location: Elkton Md.

18. Funeral director: Edw. L. Bell

Address: 909 Poplar St. Wilmington Del.

19. Oct 1 1947 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 27 19 47 at 8:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 4 1947 to Sept. 27 1947 and that I last saw him alive on Sept. 27 1947

	DURATION
Immediate cause of death: Carcinoma of the lung, right.	Apprx. 6 months
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: S. Ralph Spruance M.D.

M. D. or other

Address: 233 E. Main St. Elkton Md. Date signed: 9/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07938

Reg. Dist. No. 13-C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Rural (near Greenhurst)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: 2½ mi. East of Rising Sun
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Barnett A Yates

3.(b) Social Security Number: 06-1080

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Mary Yates

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): July 24, 1885

8. AGE: Years	Months	Days	If less than one day
62	1	26	hrs. min.

9. Birthplace: Russel County, Va
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER 12. Name: Joseph Yates

FATHER 13. Birthplace: Russel County, Va.

MOTHER 14. Maiden name: Catherine Thompson

MOTHER 15. Birthplace: Russel County, Va.

16. Informant: Mary Yates

Address: Rising Sun, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 24, 1947 (month) (day) (year)

Cemetery or crematory: Hopewell Cemetery

Location: Port Deposit, Md

18. Funeral director: Ralph M Reed

Address: Rising Sun, Md.

19. Sept 22 1947 (Date rec'd by registrar) L M Worthington Registrar

Permit issued 9-22-47

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 20 1947 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Barnett April 1947 to Sept 20 1947

and that I last saw h.. alive on Sept 18 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr.
Due to	
Due to	
Other conditions: Hypertensive Cardio Vascular disease	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W Mitchell M.D.
M. D. or other

Address: Port Deposit Date signed 9-22-47